Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-07-6304-01
Spinecare-Anes; Ben-Brig Supnet, MD 5734 Spohn Drive, Ste B Corpus Christ, Tx 78414	DWC Claim #: Injured En
Respondent Name and Box #: FIDELITY & GUARANTY INSURANCE Rep Box: 19	Date of Inj Employer Insurance

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCU

Requestor's Position Summary: "Authorization was obtained prior to services rendered. See authorization letter (Exhibit7) Carrier failed to respond to first claim sent and appeal. See proof of delivery for first and second time sent. Therefore, this claim is being submitted to MDR for determination."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $274.75
3. CMS 1500(s)
4. Anesthesia Medical Record

Sent
OCT 04 2007
TX DEPARTMENT OF INSURANCE
DIVISION OF WORKERS'
COMPENSATION

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: No position summary received.

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	CPT Code(s) and Calculations	Part V Reference	Amount in Dispute	Ordered Amount
11/16/06	01992 AA QS	1-4	$274.75	$274.75
Total:				$274.75

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.202 titled, *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

1. This dispute relates to procedure/service that was billed under procedure code 01992 AA QS for DOS 11/16/06.

2. Per Box 32 of the form CMS-1500 service was performed in Nueces County, zip code 78414. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

3. The Requestor billed with CPT code 01992 AA QS for DOS 11/16/06; Neither the Respondent nor the Requestor provided an EOB for the service; however, the requestor submitted proof of request for an EOB in accordance with rule 133.307 (e)(2)(B). Therefore, the disputed service will be reviewed according to the Medical Fee Guideline.

4. Per Rule 134.202(c)(1) reimbursement of $274.75 is recommended.

   12 minutes ÷ 15 = 0.80units
   CPT code 01992 = 5 units
   5.80 total units
   5.80 units x $47.37(conversion factor)= $274.75

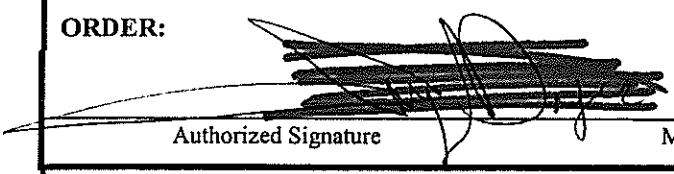
PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Sec. Section 134.1, Section 134.202
Subchapter G, Chapter 2001, Texas Government Code

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $274.75 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:



Authorized Signature	Medical Fee Dispute Resolution Officer	10/04/07 Date

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.